TO THE
NORTH CAROLINA GENERAL ASSEMBLY

BY THE
MEDICAID INVESTIGATIONS DIVISION
OF THE
NORTH CAROLINA DEPARTMENT OF JUSTICE

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I. INTRODUCTION

The Medicaid Fraud Control Unit, which in North Carolina is the Medicaid Investigations Division ("MID") of the North Carolina Attorney General's Office, is required to prepare and deliver this report pursuant to N.C.G.S. § 114-2.5A, reporting its activities to the General Assembly.

Because the MID receives 75% of its funds from a Federal source, the MID is required by its Federal funding source to maintain statistics and report its activities based on the Federal fiscal year, which is October 1 through September 30. The General Assembly requires that this report present statistics based on the state fiscal year of July 1 through June 30. Pursuant to G.S. § 1-617, the General Assembly also requires a report on qui tam cases for the calendar year of January 1 through December 31. While these three reports overlap, the statistics presented in these three reports will vary because they each cover different time periods.

G.S. § 114-2.5A requires the report on the MID's activities during the previous state fiscal year to include specific information as follows:

Information Required

(1) The number of matters reported to the MID.
(2) The number of cases investigated.
(3) The number of criminal convictions and civil settlements.
(4) The total amount of funds recovered in each case.
(5) The allocation of recovered funds in each case to
    (i) the federal government; (ii) the State Medical Assistance Program; (iii) the Civil Penalty and Forfeiture Fund; (iv) the N.C. Department of Justice; and (v) other victims.

II. OVERVIEW

The MID presents this report to the Chairs of the Appropriations Subcommittees on Justice and Public Safety and Health and Human Services of the North Carolina Senate and the North Carolina House of Representatives and to the Fiscal Research Division of the Legislative Services Office. The report covers the activities of the MID for the State Fiscal Year 2014-2015 ("FY 14/15"), covering July 1, 2014 through June 30, 2015.

The MID has worked hard to combat Medicaid provider fraud, the physical abuse of patients in Medicaid funded facilities, the misappropriation of patient funds, and fraud in the administration of the Medicaid program during our 36 year history. In that time over 560 providers have been convicted of crimes relating to Medicaid provider fraud, the physical abuse of patients in Medicaid funded facilities, the misappropriation of patient personal funds, and fraud in the administration of the Medicaid program, and the MID has recovered over $700 million in fines, restitution, interest, penalties, and costs.

However, the past fiscal year marked significant changes in the operation and reporting by the NC Division of Medical Assistance and its technological systems. Some of these changes, which will be described in more detail in Section VI, have had significant effect on how the MID accesses the expenditure of Medicaid funds and to whom, and have significantly decreased the abilities of the Medicaid Fraud Control Unit during the previous fiscal year. The problems have slowed work and have the potential to decrease fraud detection and recoveries in the next year.

The MID continues to maintain strong relationships with the North Carolina Department of Health and Human Services ("NC DHHS"), the state agency that administers the North Carolina Medicaid Program, and with other law enforcement and prosecutorial agencies. Throughout FY 14/15, the MID continued joint investigations of fraud and patient abuse cases with a number of law enforcement and investigatory agencies, including the United States Department of Health and Human Services Office of Inspector General ("OIG"), Office of Investigations District Office in Greensboro, N.C.; the Federal Bureau of Investigation ("FBI"); the Internal Revenue Service; the United States Department of Justice; N.C. State Bureau of Investigation; and local law enforcement agencies, along with integrity Special Investigations Units (SIUs) within private insurance companies. These relationships serve as a valuable resource for future case referrals.

In the spring of 1994, through the efforts of the MID and the FBI, a Federal-State Health Care/Insurance Fraud Information Sharing Task Force was organized and began its operation. Charlie Hobgood, Director of the MID, serves as co-chair of the Group. In addition to the MID and the FBI, agencies with representatives on the Task Force include the Office of Inspector General (OIG), Internal Revenue Service, Postal Inspectors, Defense Criminal Investigative Service, North Carolina Department of Insurance, and Drug Enforcement Administration, Office of Personnel Management, Criminal and Civil sections of the United States Attorney's Office for the Eastern, Middle, and Western Districts of North Carolina, the North Carolina Division of Medical Assistance Program Integrity Section (DMA/PI), and other governmental and private health care programs. The Task Force meets quarterly for discussions of ongoing matters, information sharing and training. The MID also participates in the North Carolina Medicare Medicaid (MediMedi) Project. Director Charlie Hobgood is a member of the North Carolina MediMedi Steering Committee.

As in past years, Medicaid Fraud Control Units from other states seek advice and guidance in the areas of administration, investigation, and prosecution from the MID. The MID strives to maintain and build on this reputation and to assist other units directly and through participation with the National Association of Medicaid Fraud Control Units ("NAMFCU"). During FY 14/15, MID Director Charlie Hobgood served as a member of the NAMFCU Executive Committee. Director Hobgood also chaired a NAMFCU working groups. MID Criminal Chief Doug Thoren served as Co-Chair of the NAMFCU Training Committee. MID Civil Chief Eddie Kirby was a member of the NAMFCU Global Case Committee and Qui Tam Subcommittee. MID Assistant Attorney General Steve McCallister served as Co-Chair of the NAMFCU Subpoena Working Group. The MID continues to be actively involved in national global cases being

coordinated through NAMFCU with the United States Department of Justice and other federal and state agencies. Director Hobgood, Civil Chief Eddie Kirby, Financial Investigator Camille Carrion and Assistant Attorneys Generals Steve McCallister, Stacy Race, and Mike Berger served on NAMFCU global intake groups and teams appointed by NAMFCU's Global Case Committee. MID attorneys and Financial Investigators worked on national or multistate qui tam cases as well as state non-qui tam civil cases.

The MID has worked to foster joint federal and state investigations and prosecutions of providers. The United States Attorney's Offices for the Eastern, Middle, and Western Districts have appointed a number of MID attorneys as Special Assistant United States Attorneys ("SAUSA") to pursue criminal and civil Medicaid fraud matters. MID attorneys receive many benefits from this appointment. MID attorneys are collaborating with attorneys in the United States Attorney's Offices for the Western, Middle and Eastern Districts of North Carolina on substantial criminal and civil fraud cases against a variety of Medicaid providers that began as investigations conducted by the MID. We will continue to foster our relations with these offices in the future.

The MID has a strong relationship with the North Carolina Division of Health Service Regulation ("NC DHSR"), the primary agency designated to receive patient physical abuse complaints from or involving long-term care providers in North Carolina. We anticipate our relationship with this agency will continue, which will provide the MID with a valuable source of referrals.

The MID, working with other agencies, was instrumental in developing a course through the North Carolina Justice Academy entitled, "Investigating Crimes Against the Elderly and Disabled." The course provides 24 hours of instruction and has been attended by approximately 341 law enforcement officers. This course is now being offered nationally and has been attended by officers from South Carolina and Georgia. MID Criminal Chief Doug Thoren is responsible for six hours of instruction on the legal issues surrounding abuse investigations.

During FY 14/15 the MID continued to provide an extensive training program for its staff. This training included sending staff to the NAMFCU Introduction to Medicaid Fraud 101 Training Program, the NAMFCU Medicaid Fraud 102 and 103 Training Programs, the NAMFCU Annual Training Program, the NAMFCU Global Case Training Program, and various courses relevant to fraud and abuse investigations and the use of computer programs in investigations offered by the Justice Academy of the N. C. Department of Justice, State Personnel Development Center, Office of State Personnel, and United States Attorney's Office. The MID and Division of Medical Assistance held its yearly joint training to inform all staff of various policies of both agencies to further our common mission. MID also attended and presented at training programs for Managed Care Entities.

The North Carolina General Assembly enacted the North Carolina False Claims Act, G.S. §§ 1-605 through 1-618, effective January 1, 2010. This act established a state qui tam law that

has improved the MID's ability to prosecute and investigate Medicaid provider fraud and abuse. Since the North Carolina False Claims Act became effective, the MID received information from and filings by whistleblowers alleging approximately 447 cases of Medicaid fraud and abuse.

The federal Deficit Reduction Act ("DRA") provides that if a state enacts a state false claims act that is certified by the Inspector General of the United States Department of Health and Human Services as being as effective as the Federal False Claims Act in facilitating qui tam actions by relators (whistleblowers), the state is allowed to retain an additional ten percent of the Federal share of recoveries. However, the Inspector General has determined that the North Carolina False Claims Act does not comply with DRA because it does not contain the latest revisions to the Federal False Claims Act. In order to comply with DRA, the N.C. False Claims Act should be amended by the legislature. Our staff has shared information on compliance with the legislature and remains available to pursue compliance.

The MID enjoys the full support of Attorney General Roy Cooper who has worked to enhance cooperation between government agencies in fighting health care fraud and abuse of the elderly.

In summary, the MID's activities over the past year in both the criminal and non-criminal areas have proven productive. Our successful investigation and prosecution of a variety of Medicaid providers during FY 14/15 have served to maintain and enhance our reputation as an effective and professional investigative MID that vigorously, but fairly, pursues and prosecutes fraud and abuse.

III. INFORMATION REQUIRED ON MID ACTIVIITES

1. The number of matters reported to the MID.

There were 316 referrals made to the MID during the State FY 14/15. The referrals came from varied sources. Referral sources include citizens, qui tam relators, the Program Integrity Section of the Division of Medical Assistance of the North Carolina DHHS, Managed Care Organizations (MCO) in connection with behavioral health services, the Division of Health Service Regulation, former employees, the National Association of Medicaid Fraud Control Units, United States Attorney's Offices, and other law enforcement agencies such as IRS and DEA.

Of those 316 new referrals, the MID opened new case files on 155 matters. The remaining 161 were referred to another agency for review, declined for insufficiency of the evidence, declined due to the lack of reliable data that could be used in court, or rolled into existing MID investigations. In many instances it is appropriate to refer a matter to the North Carolina Division of Medical Assistance for further review or administrative action. DMA can compare the allegation to its history of the provider and conduct billing analysis and reviews to determine whether further investigation is appropriate. DMA may then refer the matter back to the MID with the additional data and analysis. In that case, the MID can reconsider whether

to open an investigation. Alternatively, DMA may decide to apply one of the administrative remedies or sanctions it has at its disposal. It is also possible that the matter could be referred to another appropriate investigatory agency for action.

A number of referrals were declined on the grounds that the referral did not sufficiently allege Medicaid provider fraud. Some of the allegations were not substantiated by a preliminary review. In some instances the dollar amount of fraud alleged was low or the potential for successful criminal prosecution was low. Some of the allegations did not pertain to Medicaid provider fraud but rather pertained to Medicaid recipient fraud. The MID's federal grant does not allow the MID to use funding to investigate Medicaid recipient fraud. Therefore, the MID refers recipient fraud allegations to the Division of Medical Assistance and the county Department of Social Services. Please note that allegations of Medicaid recipient fraud should be referred to the Recipient Services Section of the Division of Medical Assistance, 919-855-4000, or the Fraud Section of the local county Department of Social Services.

Medicaid fraud investigations are complex and labor intensive. The consequences of a fraud conviction on a provider can be severe. Therefore, MID takes great care to ensure that allegations are substantiated before proceeding with criminal charges or civil actions.

2. The number of cases investigated.

During FY 14/15 the MID staff investigated 585 cases. Due to the length of time required to properly investigate a case, a number of these cases were referred and/or opened prior to FY 14/15. The subjects of current investigations include mental and developmental disability facilities; counselors and psychologists; physicians; dentists; psychiatrists; pharmacies; pharmaceutical manufacturers; durable medical equipment suppliers; transportation providers; home health care providers and aides; labs; nursing facilities; and hospitals. The MID is also investigating care givers accused of patient physical abuse at Medicaid funded facilities, and the theft of recipients' personal funds.

3. The number of Criminal Convictions and Civil Settlements.

a. Criminal Convictions

During FY 14/15, the MID successfully convicted 11 providers. These criminal convictions resulted in the recovery of $11,407,379.10 in restitution, fines, courts costs, supervision fees, and community services fees. Details of these convictions are set forth in Section IV of this report.

FY 14/15 was a year of significant accomplishments. Of particular note was the federal criminal conviction and 70 month sentence of Tracie Yvette Clay ("Clay"). Clay was the owner and operator of NC Behavioral Health and Counseling Services, Inc. located in Durham, North Carolina. Originally, this case was referred to the MID by the Division of Medical Assistance, Program Integrity.

During the course of the investigation, a television news report featured suspicious Medicaid claims submitted under a single psychologist's Medicaid provider identification number. It appeared impossible for a single psychologist to have actually performed the amount of services claimed and paid by Medicaid.

MID's investigation confirmed fraud had been committed. However, the investigation revealed that the psychologist was not the one responsible for the submission of the claims and was not receiving payments for the fraudulent claims. Rather, Clay was the responsible person for the criminal activity. MID's investigation determined that Clay had used the psychologist's provider number without the psychologist's permission or knowledge. Additionally, Clay used recipients' Medicaid identification numbers without their knowledge. From approximately November 2010 through March 2011, Clay submitted fraudulent Medicaid claims and was paid $990,099.58 for these claims. In regards to these claims, no services were provided and most of the recipients had never heard of Clay or her company.

This was a joint investigation with the IRS. Analysis of records showed, $218,761 of the fraudulent proceeds was spent on cars and jewelry. Through coordination with the IRS, assets estimated to be worth over $140,000 were seized and forfeited. The forfeited items consisted of several pieces of jewelry and five cars, including a Cadillac Escalade and a Mercedes-Benz.

This matter worked jointly with the United States' Attorney's Office of the Middle District of North Carolina. On September 2, 2014, in the United States District Court for the Middle District of North Carolina, Clay pled guilty to two counts of Healthcare Fraud and one count of Money Laundering. On June 11, 2015, Clay was sentenced to 70 months imprisonment to be followed by 3 years of supervised release. She was ordered to pay $990,099.58 in restitution.

MID reports all criminal convictions to the United States Department of Health and Human Services Exclusion Program which, in turn, will take administrative action to exclude these providers from future participation as providers in Medicaid and any other federally funded health care program for a period of years.

b. Civil Settlements

During this period the MID obtained 17 civil settlements and recovered $14.8 million in damages, interest, civil penalties, and costs. Of significance was a civil settlement agreement with Dr. John Shen. John Shen is a medical doctor who provides obstetrical and gynecological services in Albemarle, North Carolina. This matter was referred to the Medicaid Investigations Division by the Division of Medical Assistance, Program Integrity Section.

This settlement resolves the allegations that from January 1, 2008 through December 31, 2014, Dr. Shen performed and billed Detailed Fetal Anatomical Ultrasound Examinations, Biophysical Profile Ultrasounds and Non-Obstetrical Pelvic Ultrasounds that were not medically

necessary. Medical necessity is a requirement under Division of Medical Assistance policy for each claim submitted by a provider for reimbursement.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $975,000.00. Of that amount, the federal government received $666,533.89 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $308,466.11. Of this amount, $298,656.89 was paid to the North Carolina Medicaid Program as restitution and interest, and $9,809.22 was paid to the North Carolina Department of Justice for cost of collection and investigation.

4. The total amount of funds recovered in each case.

Together, these 11 criminal convictions and 17 civil recoveries represent a total of $26.2 million recovered for the State of North Carolina. Consistent with federal reporting instructions, recoveries are amounts individual and organizational defendants are ordered to pay in criminal cases and must pay in civil judgments and settlements and may not reflect actual collections. A case by case breakdown of the amounts recovered in each case and allocation of recovered funds is shown in Table A below.

5. The allocation of recovered funds in each case to (i) the federal government; (ii) the State Medical Assistance Program; (iii) the Civil Penalty and Forfeiture Fund; (iv) the of Justice; and (v) other victims.

The allocation of recovered funds in each case is case is shown in Table A as follows:

Table A Funds Recovered							
Name	Federal Government	NC Medicaid	Civil Penalty & Forfeiture Fund	NC DOJ Costs	Other	Total	
Claude Verbal	4,078,584.00				2,382,778.46	6,461,362.46	
Ronnie Robinson/Peaceful Alternatives	2,041,741.54	1,111,332.46			200.00	3,153,274.00	*
Tracie Clay	640,693.44	349,406.14			300.00	990,399.58	
Calvin Estrich	357,202.94	191,243.16			1,900.00	550,346.10	*
Myron Hall	73,797.81	39,947.27				113,745.08	
Joye Strong	55,729.19	30,538.91			1,000.00	87,268.10	*
Jessica Desvarieux					66,239.22	66,239.22	
Linda Burklo	26,377.15	13,957.97			784.50	41,119.62	
Lisa Fowler					29,038.04	29,038.04	
Ryce Hatchette, Jr.	8,887.02	4,802.16			100.00	13,789.18	*
Michael Dullard					755.00	755.00	
Total Criminal Recoveries	7,283,013.09	1,741,228.07	0.00	0.00	2,483,095.22	11,407,379.10	*
Dr. Marck Le/Northcross Medical Center	4,895,713.44	601,669.17	661,141.08	41,476.31		6,200,000.00	
Shire Pharmaceuticals	1,821,071.15	550,858.14	406,319.14	24,977.46		2,803,225.89	
Endo Pharmaceuticals	994,431.51	288,462.84	263,574.19	18,539.38		1,565,007.92	
Duke University Health System	872,703.08	67,378.17	57,079.11	2,839.64		1,000,000.00	
Dr. John Shen	666,533.89	298,656.89		9,809.22		975,000.00	
Organon USA, Inc. (TICE BCG)	448,062.71	245,318.72		5,748.43		699,129.86	
Organon USA, Inc. (Remeron & Remeron Soltab)		290,424.81		6,805.38		297,230.19	
Dr. Francis Bald	186,540.70	97,079.96		3,188.54		286,809.20	
Daiichi Sankyo, Inc.	181,644.22	58,028.88	39,469.83	2,592.74		281,735.67	
Omnicare, Inc.	162,536.70	23,061.42	30,184.24	982.76		216,765.12	
Dr. Calvin Kelly	123,096.92	64,372.83		2,114.29		189,584.04	
Astellas Pharma US, Inc.	112,099.14	30,480.72	21,200.39	1,748.30		165,528.55	
Dr. Maximus Frederick, MD	42,248.40	15,267.99	7,147.39	736.22		65,400.00	
Coastline Care, Inc.	16,316.51		8,991.72	295.33		25,603.56	
Medtronic, Inc.	12,979.01	6,206.25	1,528.32	250.99		20,964.57	
Community Health Systems, Inc.	8,567.77	2,268.08	2,085.50			12,921.35	
OtisMed Corporation	3,720.01	886.29	877.38	57.64		5,541.32	
Total Civil Recoveries	10,548,265.16	2,640,421.16	1,499,598.29	122,162.63	0.00	14,810,447.24	
Total Recoveries	17,831,278.25	4,381,649.23	1,499,598.29	122,162.63	2,483,095.22	26,217,826.34	*

* These defendants were ordered to repay $99,957.28 joint and severally. The Criminal Recoveries totals have been adjusted to reflect these joint and several judgments.

IV. CRIMINAL CONVICTIONS

U.S. v. CLAUDE VERBAL

Claude Verbal was the principle owner of Infinite Wellness Concepts, a Medicaid provider of mental health and substance abuse services, located in Durham, North Carolina. This case was predicated upon a referral received by the Health and Human Services Division of the Office of Inspector General (OIG). OIG reached out to the Medicaid Investigations Division for assistance. The referral alleged that Infinite Wellness Concepts was engaging in fraud and other misconduct.

The MID worked jointly with the Internal Revenue Service and the Department of Health and Human Services. The joint investigation focused on allegations of billing for services not rendered and other aberrant billing practices. The conduct covered the period of July 2009 through June 2011.

On September 11, 2014, in the United States District Court for the Middle District, Claude Verbal plead guilty to: 1 count conspiracy to defraud; 2 counts of aiding and assisting in preparation of false claims; 1 count of healthcare fraud and 4 counts of money laundering. Claude Verbal was sentenced to 135 months and ordered to pay restitution in the amount of $6,460,962.46. It was ordered that the Internal Revenue Service receive $ 4,078,584.00 and the Department of Health and Human Services receive $2,382,378.46 in restitution.

U.S. v. RONNIE LORENZO ROBINSON JR.

Ronnie Lorenzo Robinson, Jr., was the CEO, Director, and Owner of Peaceful Alternative Resources, Inc. (PAR), which had business locations in Greensboro, Mooresville, and Charlotte NC. PAR was a provider of outpatient behavioral health. This case was predicated on a referral from the Federal Bureau of Investigation. The referral alleged that a Medicaid recipient had been billed for services not rendered.

The case was worked as a joint investigation with the Western District Task Force. Investigative interviews and techniques substantiated the investigation.

On January 7, 2014, Robinson was charged on a Bill of Information in the Western District of North Carolina. He entered a plea to two counts of Heath Care Fraud. Robinson's fraudulent scheme consisted of billing for services not rendered and billing for services provided by unlicensed individuals. The period of conduct covered by Robinson's plea was from 2007 to 2012.

On January 7, 2015, Robinson was sentenced by the United States District Court for the Western District of North Carolina, to 30 months active on two separate counts of health care fraud, with the sentences to be served concurrently. Robinson was ordered to pay $3,153,074

in restitution to the North Carolina Fund for Medical Assistance, jointly and severally liable with any co-defendants.

U.S. v. TRACIE YVETTE CLAY

Tracie Yvette Clay (Clay) was the owner, president, and chief executive officer of NC Behavioral Health and Counseling Services, Inc. (NCBH) located in Durham, North Carolina. NCBH was a Medicaid Provider authorized to deliver outpatient behavioral health services. This case was referred to the MID by the Division of Medical Assistance, Program Integrity (DMA). The basis of the referral was that the IBM Fraud and Abuse Management Systems had detected suspicious billing patterns and the provider failed to provide documentation to support the billing when requested by DMA.

This was a joint investigation with the Internal Revenue Service. Several assets were seized. Interviews and investigative techniques substantiated that from approximately November 2010 through March 2011, Clay submitted fraudulent Medicaid claims for reimbursement and was paid $990,099.58 for these claims. In regards to these claims, no services were provided. Clay used recipients' Medicaid identification numbers and a psychologist's provider number without their knowledge. Analysis of records showed, $218,761 was spent on cars and jewelry. In addition to the Medicaid fraud, Clay committed the offense of money laundering.

On September 2, 2014, in the United States District Court for the Middle District of North Carolina, Clay pled guilty to two counts of Healthcare Fraud and one count of Money Laundering. On June 11, 2015, Clay was sentenced to 70 months imprisonment to be followed by 3 years of supervised release. She was also given a special of assessment of $100 for each count ($300 total). She was ordered to pay $990,099.58 in restitution.

U.S. v. CALVIN CANTRELL ESTRICH

Calvin Estrich was a partner and co-owner of Everyday's Blessing, LLC, a mental health provider in Charlotte NC. The case against Estrich was developed by the Medicaid Investigations Division in conjunction with the investigation and prosecution of Joye Strong for her involvement in Advocating for America.

The MID investigation into Strong revealed that she had fraudulently billed Medicaid for services not rendered. Further, Strong had fabricated the necessary paperwork to obtain approvals to bill services and she had falsified documents to purportedly show services to clients when, in fact, none were provided. Upon Strong's guilty plea in federal court, Strong agreed to cooperate against other fraudulent providers. Strong relayed information pointing to Calvin Estrich's involvement in a fraud scheme.

The MID investigation revealed that Estrich and Strong conspired to set up a company, Everyday's Blessing, in 2009. Estrich and Strong then created fraudulent documents to

authorize billings for services to Medicaid recipients. They created these documents by using the names and professional credentials of licensed professionals to obtain and maintain their provider endorsement and to sign necessary medical documentation. They stole the identities of recipients to bill Medicaid for over $700,000 of services they did not provide. They were ultimately reimbursed over $452,000 for those services from October 2009 to December 2010.

In November 2013, Estrich was tried in the Western District of North Carolina. Estrich was found guilty of 19 felonies, including Health Care Fraud Conspiracy, Health Care Fraud Aiding and Abetting, False Statements regarding Health Care Matters, Aggravated Identity Theft, Money Laundering and False Statements during a federal investigation. On December 10, 2014, Estrich was ordered to 63 months imprisonment and was ordered to pay $548,446.10 in restitution to the North Carolina Fund for Medical Assistance. Estrich filed Notice of Appeal to the 4th Circuit on January 5, 2015.

STATE v. MYRON HALL

This case was predicated upon a telephone call from a citizen who alleged that Myron Hall billed for mental health services for children not authorized by the Shelby Children's Clinic and who had not been referred to Hall by the Shelby Children's Clinic.

Interviews and investigative techniques substantiated the allegation. The conduct covered the period of January 1, 2008 through December 31, 2012.

On August 26, 2014, Hall pled guilty to one count of felony fraud by medical assistance provider and one count felony accessing a government computer to defraud or obtain property in Mitchell County Superior Court. In two consecutive prison sentences, Hall was sentenced to 5 to 15 months in prison followed by 13 to 25 months in prison (18 to 40 months), with 9 months post-release supervision. Hall was ordered to obtain a mental health assessment while in prison. Hall was recommended for the work release program and ordered that any money earned by Hall should be credited toward restitution. Hall was ordered to pay $113,745.08 in restitution. With Hall's consent, the restitution was docketed as a civil judgment against Hall. Hall was ordered to be excluded from the North Carolina Medicaid program.

U.S. v. JOYE STRONG

Joye Strong was the owner of Advocating for America, Inc., a mental health care provider in Charlotte, North Carolina. Joye Strong obtained a Medicaid provider number for Advocating for America, Inc. (AFA), in October 2008 and began billing for services in late January 2009. In May 2009, the Mecklenburg County Local Management Entity (LME) – an oversight agency for mental health providers – submitted a complaint to the N.C. Department of Health and Human Services, Division of Medical Assistance (DMA) alleging AFA created and/or altered person centered plans and diagnostic assessments by indicating that Helen Hayes (Hayes), a North Carolina licensed Family Nurse Practitioner (FNP), had authorized the medical necessity of services.

The MID conducted an investigation into the submission of false claims to the Medicaid Program for intensive in-home community intervention services (IIH/CIS) and mental health diagnostic assessments not actually rendered by Advocating for America, Inc. The investigation revealed that AFA billed Medicaid from January, 2009 until the Local Management Entity revoked AFA's provider endorsement. AFA received its last Medicaid payment on May 19, 2009.

Interviews and investigative techniques substantiated the allegations. It was found that Strong fraudulently billed Medicaid for 40 recipients. Thirty-two recipients were billed only for diagnostic assessments while eight were billed for both assessments and Intensive In-Home services using CPT code H2022.

On October 4, 2011, Strong pled guilty to 8 counts of Health Care Fraud in violation of 18 USC 1347 and 2 counts of Money Laundering in violation of 18 USC 1957. Strong agreed to provide the Government with assistance in a related investigation against Calvin Cantrell Estrich and Everyday's Blessing, LLC. Strong's sentencing was set after her testimony in Estrich's trial in the Western District of North Carolina. On July 16, 2014, Max O. Cogburn, District Court Judge, WDNC, sentenced Strong to a 5 year probationary sentence on all charges. Strong was ordered to pay a $1,000 assessment and ordered to pay $86,268.10 in restitution to the North Carolina Fund for Medical Assistance.

STATE v. JESSICA MAE DESVARIEUX

Jessica Mae Desvarieux (Desvarieux) was the business office manager for Greenfield Place, L.L.C., a long term health care facility located in Greenville, North Carolina. This case was predicated upon a referral received by the NC Division of Health Service Regulation, Health Care Personnel Registry Investigation Section. The referral alleged that Desvarieux embezzled over $30,000 from facility and residents' trust accounts.

Interviews and investigative techniques substantiated the allegation. The conduct covered the period of March 3, 2011 through February 4, 2014.

On November 5, 2014, Desvarieux pled guilty to two counts of felony embezzling recipient's personal funds or property in Pitt County Superior Court. In two consecutive judgments, Superior Court Judge Marvin K. Blount sentenced Desvarieux to 6 to 17 months in prison, suspended for 60 months on supervised probation. The court ordered Desvarieux to serve the first 6 months on electronic house arrest. Desvarieux was order to pay $65,137.62 in restitution to Greenfield Place, L.L.C. and was required to pay $10,000.00 towards restitution on the day of sentencing per the plea agreement. Desvarieux was ordered to complete 150 hours of community service and to comply with gambling addiction treatment. Desvarieux was ordered to pay $1,101.60 in fees. Desvarieux was ordered to have no contact with any of the victims in this case and to stay away from Greenfield Place, L.L.C. property.

STATE v. LINDA KAY BURKLO

Linda Burklo (Burklo) was the owner and operator of Burklo Homes, Inc., an enhanced respite and personal care service provider located in Hubert, North Carolina. This case was predicated upon a referral from the Division of Medical Assistance, Program Integrity alleging that Burklo falsified service documents and overbilled for Burklo Homes' service hours.

Interviews and investigative techniques substantiated the allegation. The conduct covered the period of November 2011 through October 2012.

On January 29, 2015, Burklo pled guilty to one count of felony Fraud by Medical Assistance Provider in Onslow County Superior Court. Burklo was sentenced to 6 to 17 months in prison, suspended for 24 months on unsupervised probation. The court ordered Burklo to pay $784.50 in court costs and court-appointed attorney's fee. The court entered a civil judgment against Burklo for $40,335.12 to cover the loss to the Medicaid program.

STATE v. LISA FOWLER-MOORE

Lisa Fowler-Moore (Fowler) was a CAP case manager for the Columbus County Department of Aging (CCDA). This case was predicated upon a referral from the Columbus County Sheriff's Office stating that Fowler submitted falsified work and case management documents to CCDA for services and work Fowler did not perform. CCDA billed North Carolina Medicaid approximately $68,406.05 based on Fowler's work.

Interviews and investigative techniques substantiated the allegation. The conduct covered the period of 2010 through 2012.

On June 12, 2015, Fowler pled guilty to one count of Misdemeanor Attempted Medical Assistance Provider Fraud in Columbus County District Court. Fowler was sentenced to 45 days in jail, suspended for 36 months on supervised probation. The court ordered Fowler to pay $200 in court costs and fees. The court ordered Fowler to pay $28,838.04 in restitution to cover the loss by Columbus County. Per the agreement with the government, Fowler paid $6,000.00 on the day of plea towards the restitution. The court stated that Fowler could be transferred to unsupervised probation once the entire restitution amount had been repaid.

U.S. v. RYCE EDWARD HATCHETT JR.

Ryce Edward Hatchett, Jr., was an employee of the Mecklenburg County Department of Social Services (DSS), who solicited and received kickbacks from Ronnie Lorenzo Robinson, Jr., owner of a mental health company, Peaceful Alternative Resources. This case was predicated upon information obtained during an investigation of Robinson and Peaceful Alternative Resources.

This was a joint investigation with the Federal Bureau of Investigation. The investigation showed that Hatchett, in his position as a Senior Social Worker at DSS, had access to names and identification information of DSS clients from his caseload and those of his co-workers. From November 2009 to October 2010, Hatchett gathered Medicaid recipient information and passed that information to Robinson and Peaceful Alternative Resources in exchange for a payment for each recipient's information. Robinson then used the information to bill Medicaid for services not rendered.

Hatchett pleaded guilty on January 6, 2015 in the Western District of North Carolina to one count of Illegal Remunerations involving Federal Health Care Programs. On June 23, 2015, Hatchett was sentenced to three months home detention, three years probation and ordered Hatchett to pay a $100 assessment, to complete 120 hours of community service, and to pay $13,689.18 in restitution to the NC Fund for Medical Assistance, joint and severally liable with Ronnie Robinson.

STATE v. MICHAEL VINCENT DULLARD

Michael Vincent Dullard (Dullard) worked at the McDowell House, a long term care facility, located in Nebo, North Carolina. This case was predicated upon a referral received from NC Division of Health Service Regulation, Health Care Personnel Registry Investigation Section alleging that on or about June 17, 2013 Dullard, a health care worker, abused resident Ernst Alston by putting the resident in a choke hold when the resident refused medications, which caused the resident to have pain and trauma to the neck.

Interviews and investigative techniques substantiated the allegation. The assault occurred on June 17, 2013.

On February 9, 2015, Dullard pled guilty to one count of misdemeanor assault on a handicapped person in McDowell County Superior Court. Dullard was sentenced to 75 day in jail, suspended for 18 months on supervised probation. The court ordered Dullard to complete 100 hours of community service and to comply with any anger management treatment recommended by a mental health assessment. Dullard was ordered to pay $ 755.00 in fees and costs.

V. CIVIL RECOVERIES

DR. MARK LE/NORTHCROSS MEDICAL CENTER

Northcross Medical Center is a North Carolina corporation owned and controlled by Dr. Mark Le. This matter was referred to the MID by the U.S. Attorney General's Office in the Western District of North Carolina.

This settlement resolves allegations that from December 7, 2007 through March 31, 2013, Dr. Le/Northcross Medical Center submitted claims to the Medicaid program for diagnostic tests and procedures that were not medically necessary.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $6,200,000.00. Of that amount, the federal government received $4,895,713.44 in Medicare recoveries and to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $1,304,286.56. Of this amount, $601,669.17 was paid to the North Carolina Medicaid Program as restitution, $661,141.08 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $41,476.31 was paid to the North Carolina Department of Justice for costs of collection and investigation.

SHIRE PHARMACEUTICALS, LLC

Shire Pharmaceuticals, LLC was a Delaware corporation with its principal place of business in Wayne, Pennsylvania. Shire distributed, marketed and sold drugs in the United States, including Adderall, Vyvanse, Daytrana, Lialda, and Pentasa. This matter was referred to the MID by the *qui tam* plaintiff.

This settlement resolves allegations that from January 2004 through September 2010, Shire off-label marketed its drugs Adderall XR, Vyvanse, Daytrana, Lialda, and Pentasa.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $2,803,225.89. Of that amount, the federal government received $1,821,071.15 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $982,154.74. Of this amount, $369,022.11 was paid to the North Carolina Medicaid Program as restitution and interest, $406,319.14 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $181,836.03 was paid to the qui tam plaintiff, and $24,977.46 was paid to the North Carolina Department of Justice for costs of collection and investigation.

ENDO PHARMACEUTICALS, INC.

Endo Pharmaceuticals, Inc. was a Delaware corporation headquartered in Malvern, Pennsylvania. Endo distributed, marketed and sold pharmaceutical products in the United States, including a drug sold under the trade name Lidoderm. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that from March 2009 through December 2007, Endo off-label marketed its drug Lidoderm for conditions for which it had not been approved by the Food and Drug Administration.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,565,007.92. Of that amount, the federal government received $994,431.51 to satisfy North

Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $570,576.41. Of this amount, $192,573.43 was paid to the North Carolina Medicaid Program as restitution and interest, $263,574.19 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $95,889.41 was paid to the qui tam plaintiff, and $18,539.38 was paid to the North Carolina Department of Justice for costs of collection and investigation.

DUKE UNIVERSITY HEALTH SYSTEM

Duke University Health System was a non-profit corporation that operated three hospitals: (1) Duke University Hospital, (2) Duke Regional Hospital, and (3) Duke Raleigh Hospital. This matter was referred to the MID by the qui tam plaintiff.

This settlement resolves allegations that from December 31, 2006 through February 6, 2014, Duke submitted claims for services provided by physician assistants ("PAs") during coronary bypass surgeries when the PAs were acting as surgical assistants (along with graduate medical trainees), which is not allowed under government regulations, and that Duke unbundled claims by adding Modifier 59 to certain claims when the use of Modifier 59 was not appropriate.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,000,000.00. Of that amount, the federal government received $872,703.08 in Medicare recoveries and to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $127,296.92. Of this amount, $29,378.17 was paid to the North Carolina Medicaid Program as restitution, $57,079.11 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $38,000.00 was paid to the qui tam plaintiff, and $2,839.64 was paid to the North Carolina Department of Justice for costs of collection and investigation.

DR. JOHN SHEN

Dr. Shen provided physician services to clients within the Middle District of North Carolina. This matter was referred to the MID by the Division of Medical Assistance.

This settlement resolves allegations that from January 1, 2008 through December 31, 2014, Dr. Shen performed Detailed Fetal Anatomical Ultrasound Examinations, Biophysical Profile Ultrasounds, and Non-Obstetrical Pelvic Ultrasounds that were not medically necessary.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $975,000.00. Of that amount, the federal government received $666,533.89 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $308,466.11. Of this amount, $298,656.89 was paid to the North Carolina Medicaid Program as restitution, and $9,809.22 was paid to the North Carolina Department of Justice for costs of investigation.

ORGANON USA, INC. (TICE BCG)

Organon USA, Inc. was a New Jersey corporation. Organon distributed, marketed and/or sold pharmaceutical products in the United States under the trade names of Tice BCG, NuvaRing, Cyclessa, Desogen and Mircette. This matter was referred to the MID by the qui tam plaintiff.

This settlement resolves allegations that from January 1, 1999 through September 30, 2007, Organon knowingly manipulated and failed to report its true Best Price to CMS for the sale of its drugs NuvaRing, Cyclessa, Desogen and Mircette. This settlement also resolves allegations that Organon reported inflated Average Wholesale Price ("SWP") information for its product Tice BCG and marketed the difference between acquisition cost and AWP in promoting the product.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $699,129.86. Of that amount, the federal government received $448,062.71 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $251,067.15. Of this amount, $175,019.92 was paid to the North Carolina Medicaid Program as restitution and interest, $70,298.80 was paid to the qui tam plaintiff and $5,748.43 was paid to the North Carolina Department of Justice for costs of investigation.

ORGANON USA, INC. (REMERON & REMERON SOLTAB)

Organon USA, Inc. was a New Jersey corporation. Organon distributed, marketed and/or sold pharmaceutical products in the United States under the trade names of Remeron and Remeron SolTab. This matter was referred to the MID by the qui tam plaintiff.

This settlement resolves allegations that from January 1, 1999 through December 31, 2006, Organon knowingly manipulated and failed to report its true Best Price to CMS for the sale of its drugs Remeron and Remeron SolTab. This settlement also resolves allegations that Organon paid kickbacks to Long Term Care Pharmacy providers and off-label marketed its drugs Remeron and Remeron SolTab.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $297,230.19. Of this amount, $207,200.36 was paid to the North Carolina Medicaid Program as restitution and interest, $83,224.45 was paid to the qui tam plaintiff, and $6,805.38 was paid to the North Carolina Department of Justice for costs of investigation.

DR. FRANCIS BALD

Dr. Bald was licensed to practice dentistry in the state of North Carolina. This matter was referred to the MID by a former employee of Dr. Bald.

This settlement resolves allegations that from January 2, 2010 through December 30, 2011, Dr. Bald billed for services not rendered.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $286,809.20. Of that amount, the federal government received $186,540.70 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $100,268.50. Of this amount, $97,079.96 was paid to the North Carolina Medicaid Program as restitution and $3,188.54 was paid to the North Carolina Department of Justice for costs of investigation.

DAIICHI SANKYO, INC.

Daiichi Sankyo was a Delaware corporation with its principal place of business in Parsippany, New Jersey. Daiichi Sankyo distributed, marketed, and sold drugs in the United States including, Azor, Benicar/Benicar HCT, Tribenzor and Welchol. This matter was referred to the MID by the *qui tam* plaintiff.

This settlement resolves allegations that from January 1, 2004 through March 31, 2011, Daiichi Sankyo paid kickbacks to induce physicians to prescribe their drugs. The kickbacks took the form of honoraria payments, meals and other remuneration.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $281,735.67. Of that amount, the federal government received $181,644.22 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $100,091.45. Of this amount, $40,131.53 was paid to the North Carolina Medicaid Program as restitution and interest, $39,469.83 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $17,897.35 was paid to the qui tam plaintiff, and $2,592.74 was paid to the North Carolina Department of Justice for costs of collection and investigation.

OMNICARE, INC.

Omnicare is an institutional pharmacy that provides pharmacy goods and services to residents of nursing homes and other long-term care facilities. This matter was referred to the MID by the qui tam plaintiff.

This settlement resolves allegations that from January 19, 2004 through June 30, 2012, Omnicare offered and paid remuneration to skilled nursing facilities through (a) discounted per diem pricing for drugs provided to Medicare Part A patients; (b) prompt pay discounts; (c) free drugs; and (d) discounted fee-for-service pricing for drugs provided to Medicare Part A patients, to induce the referral of the remaining pharmacy business to Omnicare, including drugs provided to patients covered by Medicaid.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $216,765.12. Of that amount, the federal government received $131,352.46 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $85,412.66. Of this amount, $30,184.24 was paid to the North Carolina Medicaid Program as restitution,

$30,184.24 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $23,061.42 was paid to the qui tam plaintiff, and $1,982.76 was paid to the North Carolina Department of Justice for costs of collection and investigation.

DR. CALVIN KELLY

Dr. Calvin Kelly was a licensed professional counselor in the state of North Carolina. This matter was referred to the MID by the Division of Medical Assistance.

This settlement resolves allegations that from January 3, 2009 through December 14, 2011, Dr. Kelly billed for services not rendered.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $189,584.04. Of that amount, the federal government received $123,096.92 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $66,487.12. Of this amount, $64,372.83 was paid to the North Carolina Medicaid Program as restitution and $2,114.29 was paid to the North Carolina Department of Justice for costs of investigation.

ASTELLAS PHARMA US, INC.

Astellas Pharma US, Inc. was a pharmaceutical company based in Northbrook, Illinois. Astellas Pharma distributed, marketed, and sold pharmaceutical products in the United States, including Mycamine. This matter was referred to the MID by the qui tam plaintiff.

This settlement resolves allegations that from January 1, 2005 through December 31, 2010, Astellas Pharma marketed and promoted the sale and use of Mycamine for pediatric patients, when the drug had not been approved as safe and effective by the Food and Drug Administration for such patients.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $165,528.55. Of that amount, the federal government received $112,099.14 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $53,429.41. Of this amount, $21,438.14 was paid to the North Carolina Medicaid Program as restitution and interest, $21,200.39 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $9,042.58 was paid to the qui tam plaintiff, and $1,748.30 was paid to the North Carolina Department of Justice for costs of collection and investigation.

DR. MAXIMUS FREDERICK

Dr. Maximus Frederick owned and operated Vistar Medical Clinic located in Raleigh, North Carolina. This matter was referred to the MID by an in house investigation in another matter.

This settlement resolves allegations that from November 4, 2008 through November 13, 2008, Dr. Frederick inadvertently benefited from the fraudulent claims submitted by Tami Creasy Newton. Tami Newton used Vistar Medical Clinic's Medicaid provider number in order to receive payments for services not rendered. Dr. Frederick deposited two Medicaid reimbursement checks that resulted in false claims submitted by Tami Newton.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $65,400.00. Of that amount, the federal government received $42,248.40 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $23,151.60. Of this amount, $15,267.99 was paid to the North Carolina Medicaid Program as restitution, $7,147.39 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $736.22 was paid to the North Carolina Department of Justice for costs of collection and investigation.

COASTLINE CARE, INC.

Coastline Care was a corporation that provided ambulance and medical transportation services in Warsaw, North Carolina. This matter was referred to the MID by OIG.

This settlement resolves allegations that from January 1, 2002 through October 1, 2006, Coastline Care submitted claims for non-emergency ambulance transports for dialysis patients whose transports were not medically necessary because the patients were ambulatory and not bed-confined.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $25,603.56. Of that amount, the federal government received $16,316.51 to satisfy North Carolina's obligation to return the federal portion of Medicaid penalties to the federal government. The North Carolina State share of the settlement was $9,287.05. Of this amount, $8,991.72 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $295.33 was paid to the North Carolina Department of Justice for costs of collection.

MEDTRONIC, INC.

Medtronic, Inc. was a Minnesota corporation headquartered in Fridley, Minnesota. Medtronic, through its Cardiac Rhythm and Disease Management business, developed, manufactured, distributed, marketed, and sold cardiac rhythm management devices in the United States, including pacemakers, implantable cardioverter defibrillators and cardiac resynchronization therapy devices. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that from January 1, 2004 through December 31, 2009, Medtronic improperly induced electrophysiologists and cardiologists to either continue to implant Medtronic devices or convert from a competitor's product to a Medtronic product. Medtronic paid these implanting physicians to speak at events that were intended to increase the referrals of those physicians.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $20,964.57. Of that amount, the federal government received $12,979.01 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $7,985.56. Of this amount, $6,206.25 was paid to the North Carolina Medicaid Program as restitution and interest, $1,528.32 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $250.99 was paid to the North Carolina Department of Justice for costs of collection and investigation.

COMMUNITY HEALTH SYSTEMS, INC.

Community Health Systems, Inc. was a Delaware corporation with its principal place of business in Franklin, Tennessee. Community Health Systems Professional Services Corporation was a Delaware corporation with its principal place of business in Franklin, Tennessee. It was an indirect subsidiary of Community Health Systems, Inc. and provided certain consulting and management services to hospitals affiliated with Community Health Systems, Inc. This matter was referred to the MID by the qui tam plaintiff.

This settlement resolves allegations that from January 1, 2005 through December 31, 2010, Community Health Systems submitted claims for certain inpatient admissions that were medically unnecessary and should have been billed as outpatient or observation services.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $13,058.35. Of that amount, the federal government received $8,567.77 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $4,490.58. Of this amount, $2,124.28 was paid to the North Carolina Medicaid Program as restitution and interest, $2,085.50 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $143.80 was paid to the qui tam plaintiff, and $137.00 was paid to the North Carolina Department of Justice for costs of collection and investigation.

OTISMED CORPORATION

OtisMed Corporation was a biotechnology corporation based in Alameda, California. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that from January 1, 2006 through November 2009, OtisMed marketed and distributed its OtisKnee Orthopedic Cutting Guide without receiving approval or clearance from the Food and Drug Administration for the device.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $5,541.31. Of that amount, the federal government received $3,720.01 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $1,821.30. Of this amount,

$886.29 was paid to the North Carolina Medicaid Program as restitution and interest, $877.37 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $57.64 was paid to the North Carolina Department of Justice for costs of collection and investigation.

VI. PROSPECTUS

Each year the MID has consistently endeavored to achieve a high standard of excellence in our efforts to effectively and efficiently combat fraud and abuse within the Medicaid Program. While we are concerned that technical and resource issues may impact recovery and conviction levels in the short-term, we continue to be optimistic about the overall progress of our efforts to combat fraud and abuse in the Medicaid Program.

Our optimism is based on several factors. First, we continue to have a reliable exchange with our Medicaid single-state agency, DMA, especially the DMA/Program Integrity Section, as well as other state and federal investigative and prosecutorial agencies. These relationships have played an important role in the MID's success to date and should significantly contribute to the MID's accomplishments in future fiscal years. We continue to be involved in numerous global/multi-state cases which have potential for successful conclusions in future fiscal years.

Further, each of the Managed Care Organizations (MCOs) managing North Carolina's Behavioral Health Managed Care 1915(b)(c) Waiver program have appointed a Compliance Officer and Committee whose duties include implementing an effective system for identifying and reporting fraud. DMA and MID have provided training to the MCOs on identifying and reporting fraud. DMA and MID have been meeting on a periodic basis with the MCO compliance staff. MCO compliance staff has shown serious interest in the training and meetings and an understanding of the importance of reporting fraud. MCO compliance staff members have become an important source of fraud referrals in connection with the Medicaid behavioral health program, and we are optimistic that this collaboration will increase.

We also anticipate that during the upcoming fiscal year the MID will be able to identify and utilize available training opportunities for all staff disciplines. These training opportunities will increase the knowledge, skills, and abilities of MID staff and enable the MID to continue to increase its proficiency in investigating and prosecuting fraud and abuse.

All MID staff members have their own personal computers that allow attorneys and investigators to obtain necessary information expeditiously and efficiently. MID also has a document imaging system that allows investigators to scan and search voluminous records rather than relying on hard copies.

The Affordable Care Act (ACA), Title 42 C.F.R. 455.23, requires DMA to suspend payments to any Medicaid provider where there is a credible allegation of fraud unless the MFCU requests that suspension not be imposed if suspension would compromise an investigation. The MID and DMA have created a process of referrals and requests not to suspend required by the regulation. As a result of this regulation, DMA has been able to

suspend Medicaid providers when appropriate in order to prevent further fraudulent expenditures of taxpayer money, and in appropriate cases MID has been able to request that suspension not be imposed if suspension might compromise or jeopardize an investigation. For a full description of the regulation please see 42 C.F.R. 455.23.

However, our optimism must be tempered by a number of challenges that MID faced including: (1) access to reliable data; (2) a decrease in referrals; (3) staffing issues; and (4) a change in the nature of civil allegations. A more detailed description of these issues and the substantial progress being made to address these issues is as follows:

First, as we noted in our September 2014 Annual Report, the 2013/2014 fiscal year saw substantial changes in MID's ability to access Medicaid data through DMA's technological systems. In past years DMA and its contractors provided MID with quick and easy access to Medicaid data through data repository and access systems including the HP DRIVE system and the Intelligent Technologies WebSPOTLIGHT system. Federal regulations require that DMA provide MID with access to Medicaid data. MID relied on these systems to efficiently and effectively prosecute fraud and recover monies.

On June 30, 2013, DMA ended its contract with its fiscal agent, Hewlett Packard (HP). On July 1, 2013 the new fiscal agent, Computer Science Corporation (CSC), took over Medicaid claims processing and payment functions and implemented a new Medicaid Management Information System (MMIS) called NC TRACKS. In addition, DHHS entered into a contract with Truven Health Analytics, Inc. (Truven) to provide a data analysis and access system called Advantage Suite. The MID was informed that the new data access and repository contracts with the new contractors were expected to become functional in September and October 2013. That did not happen. As a result, MID lost access to current data that was sufficiently reliable to be admissible in court.

Unfortunately, MID access to the pre-July 2013 DRIVE data ended in December 2013. As a result, MID lost access to both pre-July 2013 data and current data that was sufficiently reliable to be used in court.

To continue casework, before MID lost access to pre-July 2013 data, MID accessed and saved the pre-July 2013 Medicaid data from the old HP DRIVE system that remained functional through December 2013. MID was able to download data from the old DRIVE system and use it to investigate and prosecute Medicaid fraud that occurred prior to July 2013. In addition, in the past year a work-around plan was implemented whereby MID can submit case by case data requests to DHHS, and DHSS staff will obtain and verify data directly from CSC; however, the process is laborious and time consuming and can only produce a limited number of results per month. MID is also able to continue to investigate behavioral health fraud using data received from MCOs.

In January 2014, MID leadership requested from DHHS written affirmation that Medicaid data available to MID through NC TRACKS and Advantage Suite possessed a level of accuracy and reliability equal to that of previous data retrieval systems. In response, DHHS

requested meetings to discuss data issues, and by April, 2014 MID and DHHS staff and contractors met on a weekly basis for over six months to identify, discuss, and resolve data issues. In the Fall of 2014 it was concluded that this joint effort to provide MID access to Medicaid data was not successful. On February 10, 2015 Truven, the data analytics and access contractor, submitted a Corrective Action Plan (CAP) to the DMA at DHHS and to the Centers for Medicare and Medicaid Services (CMS). We are encouraged that as of August 2015 substantial progress has been achieved in implementing the CAP. While we are encouraged by efforts to resolve the data issue, the problem of access to reliable data must be resolved for MID to continue the successful prosecution and recovery of funds lost due to fraud.

Second, coinciding with the emerging data issues, referrals from Program Integrity (not including referrals originating with MCOs and submitted through Program Integrity) declined from 122 referrals to MID in FY 12/13 to 54 referrals in FY 13/14 to 20 referrals in FY 14/15. MID relies heavily on Program Integrity in identifying and referring fraud. MID is concerned that Program Integrity may have also been negatively impacted by data access issues.

Third, during FY 2013/2014 a number of MID's Financial Investigators and Financial Investigations Supervisors were paid less than the market rate established for their positions by the Office of State Human Resources (OSHR). In the case of our Financial Investigations Managers, two were making approximately 25% less than market rate. The ability to increase their salaries was limited after implementation of State guidelines that restricted State employee salary increases to 10% without sufficient written justification and OSHR and OSBM approval. During this period MID lost ten Financial Investigators and Financial Investigations Managers. While some retired, most left for jobs with private companies or other state agencies where they were able to receive substantially higher salaries. This loss placed an undue burden on remaining staff to keep up with current caseloads and made it difficult for MID to efficiently investigate Medicaid provider fraud and recover monies. DOJ made increasing investigator salaries to market rate a priority. We are pleased that in January 2015 OSHR and the Office of State Budget Management (OSBM) authorized an increase in investigator salaries to their respective market rates. This increase has allowed MID to begin rebuilding our investigative staff.

Fourth, in past years MID obtained significant civil recoveries in civil False Claims Act cases against pharmaceutical manufacturers that were alleged to have engaged in improper off-label marketing and pricing schemes. These successful civil actions may have changed the behavior of the pharmaceutical industry. We are seeing fewer allegations of off-label marketing and pricing schemes, which is good but has resulted in a decrease in amounts recovered. We are, however, successfully pursuing a larger number of civil actions alleging other violations and recovering significant amounts in these cases.

One additional recent issue will impact MID. MID operations are 75% federally funded and 25% state funded. A small part of MID's 25% state funding is received from costs of collection from civil penalties generated by our civil cases. Pursuant to G.S. § 115C-457.2, state agencies are authorized to receive up to 20% of the actual costs of collection of civil penalties.

During the past several years, OSBM authorized MID to retain cost of collection percentages ranging from 2.5% to 4.2% of civil penalties recovered. Past cost calculations included the personnel costs of MID investigators and attorneys who worked on civil cases to recover civil penalties. In August 2015 OSBM made a new legal interpretation of G.S. § 115C-457.2 that limits the costs of collection to personnel costs associated with ministerial acts such as the receipt and posting of payments and that excludes personnel costs associated with the investigation and litigation of cases to recover civil penalties. The cost of collection authorized by OSBM for MID for FY 2015/2016 was reduced to 1.11%. This reduction in the cost of collection percentage will have a negative impact on MID's budget and resources to recover funds for the state.

While these issues have the potential to continue to limit the number of convictions and amounts recovered in the next year due to the length of time required to investigate and prosecute fraud cases, because these issues are being addressed and for the other reasons cited, we remain optimistic as to the long term success of the MID. We remain committed to fight fraud and abuse in the Medicaid Program as efficiently and effectively as possible and pledge our best efforts toward the accomplishment of that goal.